STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

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K 000	INITIAL COMMENTS Stories: 1 Construction Type: V (000) Constructed: approx. 1974 Fully Sprinkled: Yes Census: 98 Certified beds: 118 A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 9/24/14 following a Tennessee Department of Health & Environment survey on 8/25/14. At this Comparative Federal Monitoring Survey, Mayfield Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	Preparation and execution for this plan of correction does not constitute an admission or agreement by the provider for the truth of the facts alleged or conclusion set forth or conclusions set forth in the alleged deficiencies. This plan of correction prepared and/or executed solely because it is required by the provisions of the Federal and State law. POC ACCEPTED OCT 27 2014	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	Gypsum board has been installed on side of wall not previously covered in medical records storage room and self-closure has been installed on door to that room in accordance with NFPA 101. Self-closure has been installed on the door to the linen Storage room.	10-16-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenny B. Ware

TITLE: Administrator

(X6) DATE: 10/15/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous area with combustible material storage over 50 SF. Findings include: On 9/24/14, at approximately 2:20 pm, the wall separating the medical records room from the training room only had gypsum board on one side of the wall and the door did not self-close. The medical records room was approximately 6 ' x13 ' At approximately 2:50 pm, the door to the linen storage room, approximately 8 ' x12 ' , in the Lighthouse unit did not self-close. Combustible storage rooms over 50 SF in buildings with automatic sprinklers shall be separated from other spaces by smoke resisting partitions and doors. The Maintenance Director acknowledged the finding when the deficiency was identified. Ref: 2000 NFPA 101 section 19.3.2.1 Failure to store combustible items as required increases the risk of death or injury due to fire and smoke. The deficiency affected 2 of 6 smoke compartments.	K 029	All other potential areas within facility with combustible material storage over 50 SF have been checked for smoke resisting partitions and self-closure compliance. The Maintenance Director will be responsible for monitoring for compliance, evidenced by monthly compliance round documentation. Audits for compliance rounds will be reported to the Quality Assurance Process Improvement Committee for three (3) months to ensure compliance.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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K 056	Continued From page 2 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install an automatic sprinkler system in all areas of the building. Findings include: On 9/24/14 at approximately 2:50 pm, a sprinkler was missing from the linen storage room in the Lighthouse unit. The room was approximately 8 ' x12 ' . The room was divided into two equal spaces by a 5 " wall with a cased door opening that had a header with a depth of 12 " . One space had tile on the wall and the other had painted gypsum board, only the portion of the room with wall tile had a sprinkler. Ref: 2000 NFPA 101 Section 19.3.5; 1999 NFPA 13 Section 5-13.8.1; CMS S&C 13-55 The Maintenance Supervisor and Administrator	K 056	Sprinkler has been installed in the linen storage room on the Lighthouse Unit in accordance with NFPA 101, 25 & 13. No other areas in the facility have been identified as to not needing this requirement. Quarterly Sprinkler System audits will be performed by outside contractor to ensure compliance with NFPA 101, 25 and 13. Any identified issues will be corrected immediately and reported to facility Maintenance Director. Maintenance Director will monitor for compliance through sprinkler contractor audits and report any findings to Quality Assurance Process Improvement Committee for two quarters, starting with the last quarter of 2014 and continuing through the first of 2015.	10-31-14

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K 056	Continued From page 3 were present when the deficiency was identified. Failure to ensure that the automatic sprinkler system is fully installed throughout the building, interior and exterior, increases the risk of death or injury due to fire. The deficiency affected 1 of 6 smoke compartments.	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system Findings include: On 9/24/14 at approximately 3:30 pm, in the kitchen there was one standard response (SR) sprinkler installed in the compartment while the others were quick response (QR), two sprinklers had paint on the frangible bulb and armature and two sprinklers had clear frangible bulb color or the fluid was missing. Ref: 2000 NFPA 101 Section 19.3.5.1, 9.7.5 1998 NFPA 25 Section 2-2.1.1 1999 NFPA 13 Section 3-2.5, Table 3-2.5.1	K 062	Two sprinklers with paint on frangible bulb and armature and two sprinklers with clear frangible bulb color or missing fluid have been replaced. All sprinklers in kitchen are now quick response (QR) sprinklers. No other sprinklers have been identified as to not be in compliance with NFPA 101, 25 & 13. Quarterly Sprinkler System audits will be performed by outside contractor to ensure compliance with NFPA 101, 25 & 13. Any identified issues will be corrected immediately and reports to facility Maintenance Director.	10-31-14

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K 062	Continued From page 4 The Maintenance Supervisor was present when the deficiency was identified. Failure to maintain the automatic sprinkler system increases the risk of death or injury due to fire and smoke. The deficiency affected 1 of 6 smoke compartments.	K 062	Facility Maintenance Director will monitor for compliance through sprinkler contractor audits and report any findings to the Quality Assurance Process Improvement Committee for two quarters, starting with the last calendar year of 2014 and continuing through the first quarter of 2015.	
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of smoke barrier walls. Findings include: On 9/24/14 at from approximately 1:00 pm -1:45 pm, the following smoke barrier walls had unsealed penetrations. 1. The smoke barrier wall near room 402 had an unsealed 3 " hole penetrated by 2 wires. 2. The smoke barrier wall near room 502: · Was missing a 4 ' x4 ' layer of gypsum board on resident corridor side of the wall. · Had two unsealed holes penetrated by 4 " sprinkler branch lines. · Had an unsealed 2 " diameter hole penetrated by 2 wires.	K 104	The smoke barrier walls with penetrations near rooms 402, 502 and room 102 have been repaired with materials that are capable of maintaining the smoke resistance of the smoke barrier in accordance with NFPA 101. All smoke barrier walls throughout facility have been audited for compliance with this regulation and repairs have been made to ensure compliance. To ensure this practice does not recur, going forward, our facility Maintenance Director will be inspecting any activity or work done in our attic space before contractors leave, upon completion of any such work.	10-31-14

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K 104	Continued From page 5 3. The smoke barrier wall near room 102 had an unsealed 2 " x3 " hole penetrated by two wires. The space between a penetrating item and the smoke barrier is required to be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. Ref: 2000 NFPA 101 Section 19.3.7.3, 8.3.6.1 The Maintenance Supervisor was present when the deficiency was identified. Failure to maintain the smoke resistance of smoke barriers increases the risk of death or injury due to smoke. The deficiency affected 5 of 6 smoke compartments .	K 104	Facility Maintenance Director will monitor for compliance and report any inspection findings to Quality Assurance Process Improvement Committee for two quarters, starting with the last calendar year quarter of 2014 and continuing through the first quarter of 2015.	